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RESEARCH ARTICLE

PELLAGRA: A RARE COMPLICATION OF ANOREXIANERVOSA

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Abstract

Althoughpellagraappears to be a rare entitynow, itcanstilldevelop. It is important to recognize how the diseasemanifests to ensureproper and prompt treatment.Wepresenta case of pellagrasecondary to anorexianervosa in a 25-year-old woman.

Introduction:-

Pellagrais a rare systemicdisease, with a clinicaltriad of skin, digestive and sometimesneurologicalsymptoms, whichcanbeseenatanyage and is more frequent in developing countries. It issecondary to a deficiency of niacin (vitamin PP or B3). In case of delay in diagnosis and treatment, pellagrais fatal(1)

We report the observation of pellagrasecondary to anorexianervosa in a young 25 yearoldfemale patient.

Observation:-

The patient was 25 yearsold and had a history of acromegalysecondary to an operatedpituitaryadenoma, complicated by adrenal and thyroidinsufficiency.

Hospitalized for alteration of the general state, withasthenia and a weightloss of 15kg, evolvingfor three months.

The interrogation revealedeatingdisorderssuch as restrictive anorexianervosa.

The clinicalexaminationfound a hypotensive patient (BP 90⁄52 mmHg), bradycardic (FC:56bpm)the dermatologicalexaminationhighlighted a skin rash made of hyperpigmented patches withsharp contours coveredwithichthyosiformscales (fig1, 2). Theselesionswerelocatedbilaterally and symmetrically on the backs of the hands and feet, and wereassociatedwithfissured dry cheilitis and depapillatedglossitis.

The neurologicalexaminationrevealed a neurologicaldisordersuch as bradypsychia and memoryimpairment.

Moreover, the patient did not report any digestive disorders.

Dermoscopyshowed (fig3) white scales on a pigmented background.

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The skin biopsyshowed the presence of aparakeratotichyperkeratosisassociatedwith a focal pigmentary incontinence.

Biologicalworkuprevealed a malabsorption syndrome (Hypoalbuminemia, microcyticanemia, lowferritinemia).

Fibrocoloscopy and thoracic-abdominal-pelvic CT scan were normal; vitamin B1, B6, B12 and zinc levelswere not available.

The diagnosis of pellagrawas retained.A high-calorie; high-proteindiet and oral niacinsupplementationwereprescribed. The skin lesionsimprovedsignificantly but did not completelydisappear. The patient wasreferred to a psychiatric consultation for treatment.

Discussion:-

Pellagraiscaused by a cellular deficiency of niacin or itsprecursoraminoacid; tryptophan.

Primarypellagraoccurswhenthereis a dietarydeficiency of tryptophan or niacin. Secondarypellagraiscaused by conditions characterized by interferencewith the absorption or metabolism of tryptophan and niacin, such as anorexianervosa, chronicalcoholism, prolongeddiarrhea, ileitis, colitis, cirrhosis, carcinoid syndrome, Hartnup'sdisease and HIV.(2)

Neurologicsymptoms are usuallysubtle and nonspecific, but if leftuntreated, mayprogress to deathfrommultiorganfailure. (3)Therefore, mucocutaneoussignsprovide important diagnostic clues. The diagnosis of pellagraisclinical; Itpresents as an acute, symmetrical, erythematous rash, welldemarcated in the photo-exposed areas; and isconfirmed by a rapidresponse to oral nicotinamide when up to 500 mg per day in divided doses isadministered(4)

Histologyis non-specific(5)vitaminassaysshould not delaytreatment. Substitutive treatment leads to a rapide rgression of cutaneous, neurological and digestive signs. Polyvitamin complexes are oftennecessarybecause of multiple vitamindeficiencies. Etiologicaltreatmentis essential.

In patients withanorexianervosa, the signs of pellagramaybeatypical and overlapwithothernutritionaldeficiencies(6, 7)

Our patient did not initiallypresentwithobvioussigns of anorexianervosa or body image problems. The diagnosiswas made onlyafterclinical suspicion led to a carefulexamination of the dietaryhistory.

Conclusion:-

Although rare, pellagrais a diseasethatisstillprevalent and deserves to beknownbecause of itspotentially fatal course.

Figures:

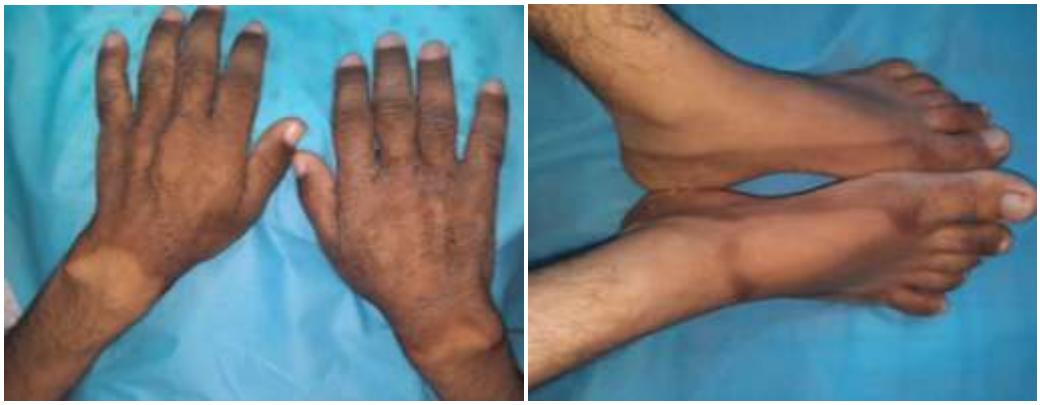

Fig1, 2:-Bilateral, symmetrical, and scalydermatitiswithhyperkeratosis in photoexposed areas of both hands and feet.

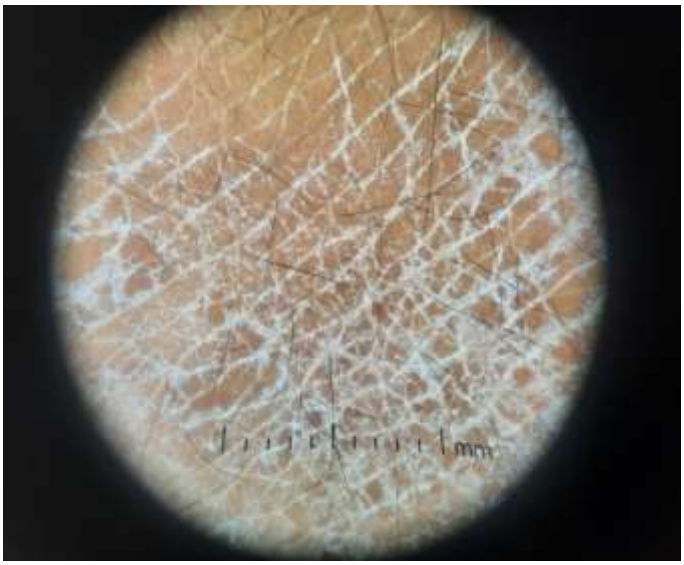

Fig3:- White scales on a pigmented background.

Conflict of interest:
There is no conflict of interest of any of the authors.

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